STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR RIDGE	2700 WATERS EDGE PKWY JEFFERSONVILLE, IN 47130

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R000000	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00148860. Complaint IN00148860- Substantiated - No deficiencies related to the allegations are cited. Survey dates: July 14, 15 and 16, 2014 Facility number: 004001 Provider number: 004001 AIM number: N/A Survey team: Gloria J. Reisert, MSW Census Bed Type: Residential: 36 Total 36 Census Payor Type: Medicaid: 23 Other: 13 Total 36 Residential Sample: 07 Supplemental Sample: 02 These State findings are cited in accordance with 410 IAC 16.2-5.	R000000	Submission of this plan of correction does not constitute admission or agreemet by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies.This plan of correction is prepared and submitted because of requirement under state and federal law.Please accept this plan of correction as our credible allegtion of compliance.Please consider paper compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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	Quality Review completed on July 22, 2014, by Brenda Meredith, R.N.			
R000092	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift	R000092	R0092 Requires the facility to ensure the fire drills were conducted quarterly on each shift	07/17/2014

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	with at least 12 fire drills a year. This deficient practice had the potential to affect 36 of 36 Residential residents currently residing in the facility. Finding includes: On 7/14/14 at 12:30 p.m., review of the Annual Fire Drills Log , dated between July 2103 and June 2014, indicated the following quarterly drills had not been conducted: July, August and September 2013: Night Shift Drill October, November and December 2103: Day and Evening Shift Drills April, May and June 2014: Evening and Night Shift Drill During an interview with the Administrator on 7/14/14 at 2:00 p.m., she indicated that she had spoken with the former Administrator who had told her that the fire drills were held to meet the regulation of 12 a year but was not sure where the documentation was. During a second interview with the Administrator on 7/15/14 at 1:45 p.m., she indicated that she was unable to find the missing fire drill records.		with at least 12 fire drills a year. 1. The Maintenance Director was re-educated as to the regulatory requirement.2. As all resident could be affected, the following corrective actions will be taken:3. The staff have been in-serviced and re-educated on the fire drill policy. The fire department is scheduled to come to the building and do a walk thru on July 31st. As a means to ensure ongoing compliance, after initial in-service, the Administrator will observe and check off monthly fire drills. 4. As a means of quality assurance, the administrator will then ensure the fire drills were conducted by reviewing the fire drill logs as follows: July 2014- 1st shift, August 2014- 2nd shift, September 2014- 3rd shift, and rotated monthly thereafter in same sequence ongoing. See attachment A. Should non-compliance be observed, corrective action will be taken.	

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R000144	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation and interview, the facility failed to ensure lighting fixtures and sprinkler heads were free of dust accumulation; ceiling vents in 1 of 1 dining room were clean; and a sprinkler head and ceilings in hall by courtyard and dining room were free of cracks and in good repair. This deficient practice had the potential to affect 36 of 36 residents who currently reside in the facility during 2 of 2 environmental tours. (July 14 and 15, 2014) Findings include: A. During the environmental tour on 7/14/14 between 1:10 p.m. and 1:30 p.m., the following was observed in the Dining Room: 1. One (1) of 16 chandeliers had light to moderate dust accumulation on the globes with cobwebs hanging down over the residents' tables. 2. Two (2) of 8 Sprinkler heads had cobwebs hanging down over the residents' tables.	R000144	R0144 Requires the facilty to ensure lighting fixtures and sprinkler heads are free of dust accumulation, ceiling vents are clean and ceilings in hall by courtyard and dining room are free of cracks and in good repair. The facility will ensure this requirement is met through the followig corrective measures. 1.All identified areas have been corrected:A1 Chandeliers were dusted and globes were cleaned and remain free of cobwebs. A2. Sprinlkler heads were cleaned and remain free of cobwebs.A3 Ceiling vents were cleaned and remain free of dirt/dust or build up on the vents.A4 The 2 foot crack in the ceiling above the steam table has been repaired.B1 Dining room chandeliers were dusted and globes were cleaned and remain free of cobwebs.B2 The Sprinkler head in the laundry room ceiling was cleaned and the gray dust was removed from the head of the sprinkler.B3 Sprinkler head at the beginning of the hall between Apartment #19 and 129 sprinkler head was cleaned and dusted.B4 The sprinller head ring in front of the mirror just before the courtyard exit door by Apartment 133, was repaired and is corrected.B5. The sprinkler	07/28/2014

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	3. Four (4) of 6 ceiling vents had a build up of black dirt/dust on and surrounding the vents. 4. A 2 foot crack in the ceiling above the steam table which was observed to have been repaired previously but had cracked again. B. During the environmental tour on 7/15/14 between 5:00 p.m. and 5:45 p.m. while accompanied by the Administrator, the following was observed: 1. The same issues were again observed in the dining room as previously identified on 7/14/14 at 1:10 p.m. 2. One (1) of 3 sprinkler heads in the laundry room ceiling had a moderate amount of gray dust on the head. 3. One (1) of 6 sprinkler heads at the beginning of the hall between Apartment 139 and 129 had dust hanging from the head. 4. The sprinkler head ring in front of the mirror just before the courtyard exit door by Apartment 133, was hanging loose slightly from the ceiling. 5. The sprinkler head by the exit door and fire exit sign by Apartment 123 was		head by the exit door and fire exit sign by Apartment 123 was missing the ring between the head and the ceiling. The ring was replaced correcting the deficiency.B6 A 3 foot jagged crack in the ceiling across from Apartment 121 by the windows was re-sanded and plaster applied.2. As other areas of the facility could be affected, the following actions were taken: Facility rounds were made in an effort to identify any other areas in need of cleaning and/or repair with corrective actions taken, as warranted.3. In an effort to ensure ongoing compliance, the staff were re-educated on reporting any concerns to the administrator upon discovery. The Administrator will conduct weekly rounds to affirm continued compliance with identification of concerns and timely cleaning/repair thereof. (See Attachment B). 4. As a means of quality assurance, facility wide observations will continue to be conducted at various times on a weekly basis with continued tracking of timely cleaning/repairs. The Administrator shall report to the Regional Manager continued monitoring and compliance with timely cleaning/repairs on a monthly basis ongoing.	

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	missing the ring between the head and the ceiling. This allowed one to be able to see past the head into the ceiling and the wires. 6. A 3 foot jagged crack in the ceiling across from Apartment 121 by the windows was observed. This area had been previously repaired but had cracked again. The plaster was also observed to be blistering in places. On 7/16/14 at 11:00 a.m., the Administrator indicated she had spoken with the Director of Maintenance who indicated he was not aware of the crack above the steam table in the dining room. She also indicated that he had worked so hard in making repairs to the ceiling and patching the cracks and that the crack in the hall ceiling must have re-cracked due to the blasting being done outside.			
R000409	410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on record review and interview, the facility failed to ensure annual health	R000409	R 409 The facility will ensure annual health statements which indicated the residents were free	07/28/2014

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	statements which indicated the residents were free from communicable diseases, including Tuberculosis, were completed at time of admission and annually. This deficient practice affected 3 of 7 residents and 2 of 2 supplemental residents reviewed for annual health statements. (Residents #3, #5, and #7) Findings include: 1. Review of the clinical record for Resident #3 on 7/15/14 at 11:00 a.m., indicated the resident had diagnoses which included, but were not limited to: non-insulin diabetes mellitus and hypertension. Documentation was lacking of a current annual health statement having been completed by the physician to indicate the resident was free of communicable disease. 2. Review of the clinical record for Resident #5 on 7/15/14 at 9:05 a.m., indicated the resident was admitted to the facility on 4/25/13 with a subsequent re-admission from the hospital on 5/15/14. Diagnoses included, but were not limited to: diabetes mellitus, congestive heart failure with valve repair, and coronary artery disease.		from communicable diseases, including Tuberculosis, and completed at time of admission and annually. The facility will ensure this requirement is met through the following measures. R409 Infection Control – noncompliance 1. Current health statements completed by the physician to indicate the resident was free of communicable diseases obtained for Residents #3 #5 and #7 2. The medical records of all residents were audited to confirm timely skin testing performed and documented, or alternate means (chest x-ray and/or health screen) obtained if the resident is a known positive reactor. Audit confirmed the presence of a health statement indicating the residents had no evidence of tuberculosis in an infectious stage.3. As a means to ensure ongoing compliance, nursing staff has been educated as to resident skin testing as per policy/rule, and the regulatory requirement to have a health statement indicating the resident has no evidence of tuberculosis in an infectious stage upon admission and yearly thereafter. The DON shall be responsible to ensure said testing is completed and/or scheduled for each newly admitted resident and placed on a calendar for annual testing thereafter, as well as health statement documented.4. As a means of	

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	Documentation was lacking of an annual health statement having been completed by the physician to indicate the resident was free of communicable disease since admission. 3. Review of the closed clinical record for Resident #7 on 7/15/14 at 9:50 a.m., indicated the resident was admitted tot he facility on 2/27/14 and had diagnoses which included, but were not limited to: hypertension, diabetes mellitus, cerebrovascular disease - history of stroke. Documentation was lacking of an annual health statement having been completed by the physician to indicate the resident was free of communicable disease since admission. During an interview with the Corporate Nurse Consultant and the Director of Nursing on 7/16/14 at 11:30 a.m., they indicated they were in the process of notifying the physicians for any resident who did not have an annual health statement.		quality assurance, the Administrator or her designee shall monitor all new admissions by completing an audit of the new admission chart with 72 hours of admission. Should non-compliance be noted, applicable staff will be re-educated, and disciplinary action taken, as warranted. The DON shall maintain an ongoing calendar and review monthly those residents due for annual testing to ensure said testing is scheduled and completed and corresponding health statement documented as per rule. The DON will audit all new admissions and review monthly ongoing. See attachment C	